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Unannounced Inspection Report

Maternity Services Safe Delivery of Care Inspection

Ninewells Hospital

NHS Tayside

27-29 January 2025

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About our inspection

Background

In November 2021 the Cabinet Secretary for Health and Social Care approved Healthcare Improvement Scotland inspections of acute hospitals across NHS Scotland to focus on the safe delivery of care. In response to Healthcare Improvement Scotland's Neonatal Mortality Review in 2024, Healthcare Improvement Scotland made a commitment to expanding our safe delivery of care inspection approach to include inpatient maternity services. The methodology was adapted to minimise the impact of our inspections on staff delivering care to women, birthing people and families. Our inspection teams carry out as much of their inspection activities as possible through observation of care and virtual discussion sessions with senior hospital managers.

From April 2023 our inspection methodology and reporting structure were updated to fully align to the Healthcare Improvement Scotland Quality Assurance Framework. Further information about the methodology for maternity services safe delivery of care inspections can be found on our website.

Our Focus

Our inspections consider the factors that contribute to the safe delivery of care. In order to achieve this, we:

- observe the delivery of care within the clinical areas in line with current standards and best practice
- attend hospital safety huddles
- engage with staff where possible, being mindful not to impact on the delivery of care
- engage with managers to understand current pressures and assess the compliance with the NHS board policies and procedures, best practice statements or national standards, and
- report on the standards achieved during our inspection and ensure the NHS board produces an action plan to address the areas for improvement identified.

About the hospital we inspected

1. Ninewells Hospital is a large teaching hospital located in Dundee, Scotland. It provides 24 hour emergency care, intensive care facilities, surgical specialties, maternity and paediatrics, major trauma and oncology services.

About this inspection

We carried out an unannounced maternity services inspection in conjunction with a hospital safe delivery of care inspection to Ninewells Hospital, NHS Tayside on Monday 27 to Wednesday 29 January 2025 using our safe delivery of care inspection methodology. We inspected the following areas during the maternity inspection:

- labour ward
- maternity Triage
- ward 38 North inpatient Antenatal care
- ward 38 South inpatient Postnatal care

During our inspection, we:

- inspected the ward and hospital environment
- observed staff practice and interactions with women and birthing people
- spoke with women, families, visitors and ward staff, and
- accessed health records, monitoring reports, policies and procedures.

As part of our inspection, we also asked NHS Tayside to provide evidence of its policies and procedures relevant to this inspection. The purpose of this is to limit the time the inspection team is onsite, reduce the burden on ward staff and to inform the virtual discussion session.

On Wednesday 12 February 2025, we carried out an unannounced revisit to maternity services within Ninewells Hospital to seek assurance in relation to a number of concerns we raised on the initial inspection.

Throughout February and March 2025, we held several virtual discussion sessions with key members of NHS Tayside staff to discuss the evidence provided and the findings of the hospital inspection.

The findings detailed within this report relate to our observations within the areas of the hospital we inspected at the time of this inspection.

We would like to thank NHS Tayside and in particular all staff at Ninewells Hospital for their assistance during our inspection.

A summary of our findings

Our summary findings from the inspection, areas of good practice, recommendations and requirements identified are highlighted as follows. Detailed findings from the inspection are included in the section ‘What we found during this inspection’.

During inspection we observed staff providing compassionate and responsive care to women and their families. Women we spoke with were complimentary of care provided. We observed good teamwork including obstetricians, midwives and the

health care support team. Women and their families were complimentary about the service and advised us they would be happy to recommend NHS Tayside maternity services to family and friends.

We were able to attend the multidisciplinary team handover within labour ward which was attended by members of the obstetric, midwifery and anaesthetic team. This provided a comprehensive overview of women within maternity services. This was led by the consultant team and good discussions were evident, promoting oversight and situational awareness.

As a result of concerns identified during inspection that required immediate improvement, we carried out an unannounced revisit on Wednesday 12 February 2025. The concerns related to variation in practice to assessing women within maternity triage and to staff access and awareness of retrieval of emergency medication within the maternity triage department. We also sought assurance on processes in place to support quality improvement and assurance of care within the antenatal/postnatal ward. During the revisit we were not assured that sufficient progress or improvement had been made with some of our concerns therefore, we formally wrote to NHS Tayside Executive team outlining areas of assurance required, highlighting culture, variance between the oversight and governance observed in both the hospital inspection and the maternity services inspection and lack of oversight by senior management within maternity services as emerging areas of concern. NHS Tayside responded with details of immediate improvement actions taken.

Other areas for improvement include assurance of safe staffing, fire safety issues, water flushing for infrequently used water outlets and the management of the maintenance of the hospital environment. These areas for improvement were also highlighted in the acute hospital inspection of Ninewells Hospital. Inspectors observed that the current layout of labour ward has impacted upon the provision of accessible toilets to women during labour which can compromise dignity.

What action we expect the NHS board to take after our inspection

This inspection resulted in nine areas of good practice, three recommendations and 20 requirements.

A requirement in the inspection report means the hospital or service has not met the required standards and the inspection team are concerned about the impact this has on women, birthing people and families using the hospital or service. We expect all requirements to be addressed and the necessary improvements implemented.

A recommendation relates to best practice which Healthcare Improvement Scotland believe the NHS board should follow to improve standards of care.

We expect NHS Tayside to address the requirements. The NHS board must prioritise the requirements to meet national standards. An improvement action plan has been developed by the NHS board and is available on the Healthcare Improvement Scotland website: http://www.healthcareimprovementscotland.scot.

Areas of good practice

The unannounced inspection to NHS Tayside, Ninewells Hospital maternity services resulted in nine areas of good practice.

Domain 1	
1	Wards inspected were calm with good visibility of staff and clinical leadership (see page 16).
2	We observed a dedicated bereavement room which encompassed an area to allow the full in hospital bereavement journey to be undertaken (see page 16).

Domain 2	
3	We observed clinical leaders within maternity services being approachable and engaging with all team members (see page 19).
4	New members of the multidisciplinary team reported feeling able to discuss concerns and escalate any issues (see page 19).
5	An incident trigger list which aims to encourage submission of incident report forms following an adverse event was in place to support review and learning (see page 19).

Domain 4.1	
6	We observed families being supported by the infant feeding team and wider staff groups to build confidence in their chosen feeding method of their baby (see page 24).

Domain 4.3	
7	NHS Tayside utilise a variety of initiatives to support staff health and wellbeing (see page 28).

Domain 6	
8	All observed interactions between women, staff and visitors were positive and respectful (see page 30).
9	We observed staff working hard to provide compassionate, responsive and respectful care (see page 30).

Recommendations

The unannounced inspection to Ninewells Hospital maternity services resulted in three recommendations.

Domain 1	
1	NHS Tayside should ensure improvement in their assurance of staff bereavement training (see page 16).
2	NHS Tayside should ensure processes are in place to support mothers and

	babies to have access to family centred care with extended family members actively encouraged to engage in maternal and newborn care (see page 16).
3	NHS Tayside should consider ways to improve oversight and staff feedback of interpretation services, to ensure any areas for improvement can be identified and addressed (see page 16).

Requirements

The unannounced inspection to Ninewells Hospital maternity services resulted in 20 requirements.

Domain 1	
1	NHS Tayside must ensure a system is in place to monitor women requested to attend for review following telephone triage and should inform women of the urgency and timeframe for attendance (see page 16). This will support compliance with: Health and Social Care Standards (2017) 3.21.
2	NHS Tayside must ensure signage is in place to provide clear instruction and direction to the public within the hospital environment. This includes, but is not limited to, maternity triage (see page 16). This will support compliance with: Healthcare Improvement Scotland Quality Framework (2018) and Quality Assurance Framework (2022) criteria 6.1.
3	NHS Tayside must ensure effective oversight of guidance and process within maternity triage to support safe delivery of care (see page 16). This will support compliance with: Healthcare Improvement Scotland Quality Framework (2018) and Quality Assurance Framework (2022) Criteria 2.5 and 2.6.
4	NHS Tayside must ensure medication required for emergency treatment is accessible to staff with effective oversight and assurance of staff knowledge of process (see page 16). This will support compliance with: Healthcare Improvement Scotland Quality Framework (2018) and Quality Assurance Framework (2022) Criteria 2.4 and 2.6
5	NHS Tayside must ensure effective oversight to ensure essential patient equipment is in working order and ready for use. This includes, but is not limited to, fetal monitoring equipment (see page 17). This will support compliance with: Health and Social Care Standards (2017) criteria 4.14 and Healthcare Improvement Scotland Quality Assurance Framework (2022) criteria 2.6.

6	NHS Tayside must ensure improvement in governance and oversight of ethnicity completeness data for all women and birthing people booking for perinatal care (see page 17). This will support compliance with: Healthcare Improvement Scotland Quality Framework (2018) and Quality Assurance Framework (2022) Criteria 2.4 and 2.6.
7	NHS Tayside must ensure all fire exit signage is present and maintained to ensure safe fire evacuation and actions and improvements identified within fire safety risk assessments are addressed (see page 17). This will support compliance with: Fire Safety (Scotland) Regulations (2006).

Domain 4.1	
8	NHS Tayside must ensure venous thromboembolism guidance and risk assessments in place are aligned to support staff during the risk assessment of venous thromboembolism (see page 24). This will support compliance with Quality Assurance Framework (2022) Criteria 2.6.
9	NHS Tayside must ensure robust processes are in place to support quality assurance processes within maternity services (see page 24). This will support compliance with Health and Social Care Standards (2017) criteria 4.11 and Quality Assurance Framework (2022) Criteria 2.6.
10	NHS Tayside must ensure effective systems and processes are in place to support assurance of a safe healthcare environment and that all essential maintenance works are completed (see page 24). This will support with compliance of National Infection Prevention and Control Standards (2022) and Infection Prevention and Control Standards, Criteria 8.1.
11	NHS Tayside must ensure compliance with SICPS. This includes, but is not limited to: a. hand hygiene b. linen management c. sharps management (see page 24) This will support compliance with: National Infection Prevention and Control Standards (2022).
12	NHS Tayside must ensure all hazardous cleaning products are securely stored and labelled appropriately, as per manufacturers' guidelines (see page 24).

	This will support with compliance of Control of Substances Hazardous to Health (COSHH) Regulations (2002).
13	NHS Tayside must ensure that clinical waste is stored in a designated safe, lockable area whilst awaiting uplift and staff are aware of how to escalate if there is a buildup of clinical waste awaiting uplift (see page 24). This will support compliance with: National Infection Prevention and Control Manual (2023).
14	NHS Tayside must ensure infrequently used water outlets are flushed in line with current national guidance (see page 24). This will support with compliance with National Infection Prevention and Control Manual (2023) and Scottish Health Technical Memorandum SHTM 04-01 part B (2014) 'Water Safety for healthcare premises Part B:Operational management'.
15	NHS Tayside must ensure the appropriate management and monitoring is in place to ensure the safe storage of medicines (see page 24). This will support compliance with: Royal Pharmaceutical Society on the Administration and storage of Medicines in Healthcare Settings (2019) and Nursing and Midwifery council (NMC) The code (2018).

Domain 4.3	
16	NHS Tayside must ensure that clear and robust systems and processes are in place to allow consistent assessment and capture of real time staffing risk across all clinical professional groups within maternity services, to support consistent management of any identified staffing risks. This must include feedback to staff regarding decisions undertaken (see page 29). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
17	NHS Tayside must ensure there are clear systems and processes in place for the monitoring and mitigation of any severe and/or recurring staffing risk within maternity services to support longer term workforce planning and service improvement (see page 29). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
18	NHS Tayside must ensure that there are clearly defined systems and processes in place within maternity services to support effective leadership and oversight relating to appropriate staffing requirements as defined within the Health and Care (Staffing) (Scotland) Act 2019.This includes, but is not limited to, the

	monitoring and mitigation of the impact of staffing challenges, including reduced skill mix (see page 29). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
19	NHS Tayside must ensure they are complying with the duty imposed by section 12II, ensuring that its employees receive time and resources to undertake such training essential to their role (see page 29). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
20	NHS Tayside must ensure that there are systems and processes in place to support clinical leaders within maternity services being able to access appropriate protected leadership time to fulfil their leadership and management responsibilities. This will include consistent monitoring and recording of when and why this is sacrificed as part of mitigation for staffing shortfalls (see page 29). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.

What we found during this inspection

Domain 1 – Clear vision and purpose

Quality indicator 1.5 – Key performance indicators

Despite increased acuity, we observed staff working hard as a team to deliver care. We observed oversight of the induction of labour process and mitigations put in place when delays to the induction of labour process occurred through the use of a risk assessment tool. However, we raised concerns regarding assurance of a standardised approach to initial assessment when women presented to maternity triage.

The vision for maternity services in Scotland was set out in 2017 by Scottish government within The Best Start: A five-year forward plan for maternity and neonatal care in Scotland. Further information can be read here.

At the time of inspection maternity services based within Ninewells Hospital were experiencing pressures, like many of NHS Scotland services, such as reduced staff availability and increased patient acuity.

On the first day of our onsite inspection, we observed delays within the maternity triage department. Maternity triage is a specialised assessment area which provides 24 hours a day, seven days a week unscheduled (emergency) care to women during

pregnancy and within the postnatal period. Maternity triage within Ninewells Hospital provides care to pregnant women from 14 weeks of pregnancy until birth and from birth to six weeks postnatal.

Obstetric emergencies and concerns over the wellbeing of the unborn baby are time sensitive requiring a systematic approach which identifies women of the highest clinical priority to improve outcomes. There is currently no national standardisation of maternity triage system available. However, the Royal College of Obstetricians and Gynaecologists good practice paper on maternity triage and the National institute for Health and Care guidance recommend each board develops their own guidance based on an evaluated system. Further information can be found here.

In Ninewells Hospital maternity triage is accessed following a telephone assessment carried out by midwives, allowing maternity staff oversight of women attending the service. Best practice described by the Royal College of Obstetricians and Gynaecologists recommends telephone triage is undertaken by a midwife dedicated to triaging calls for all or part of their shift. Outcomes of telephone triage can include signposting of women to other available care such as their general practitioner, telephone advice or admission to the maternity unit for review. During onsite inspection we observed that telephone triage wasn't assigned to a dedicated member of staff and staff advised us that no current systematic approach to telephone triage was in place. Staff also informed us once women confirmed they will attend the maternity triage unit, following an assessment carried out by a midwife, there is no process to follow up with any women who fail to attend the triage unit, preventing welfare checks being undertaken where necessary. The Royal College of Obstetricians and Gynaecologists recommends recording details of all women who have been asked to attend maternity triage departments and that the urgency and timeframe for attendance is explained to the woman during the telephone triage. A requirement has been given to support improvement in this area.

The triage service is provided within two areas of the hospital, Monday to Sunday 0700-2200. Triage is provided within a five bedded area situated alongside the obstetric antenatal clinics, outpatient induction of labour clinic and maternity daybed unit which provide scheduled (planned) care. Out with these times, two rooms are allocated for triage within labour ward. The National Institute for Health and Care guidance recommends maternity units provide clear information about the location of triage units, when to call and when to attend. On discussion with staff and senior managers, we asked how women are informed of the change to the triage location. We were told that women were advised where to attend during their telephone triage. Within the main hospital corridor, we observed some signage to guide women and families to maternity triage, however this was limited and not easy to follow. Signage within the hospital settings should provide clear instruction and direction to the public and staff. During discussion with senior managers, we were informed of work being undertaken to review and improve signage throughout the hospital which will include maternity triage. Senior managers told us no adverse events had occurred

due to the triage service being delivered in different locations or due to lack of signage. A requirement has been given to support improvement in this area.

On admission to a maternity triage unit best practice guidance from the Royal College of Obstetricians and Gynaecologists recommends a prompt and brief assessment is carried out to assess the clinical urgency by which women and birthing people should be reviewed. Senior managers told us NHS Tayside are planning to adopt The Birmingham symptom specific obstetric Triage system (BSOTS) in 2025. The Birmingham symptom specific obstetric Triage system is an evaluated system that assesses and prioritises pregnant women with unexpected problems or concerns. The aim of the system is to improve safety, efficiency and communication. However, this is not yet in place, and during the inspection we observed there was no standardised approach to this initial assessment. Staff told inspectors that scheduled care is also being provided in the triage area and this impacted on their ability to prioritise triage. Whilst staff endeavoured to ensure women attending were triaged within 30 minutes this was not always possible. Delays to the initial triage assessment can result in delayed treatment during obstetric emergencies and impact on the health of women and their unborn baby. Senior managers told us that guidance was in place to support staff with clinical prioritisation of women which included escalation to senior managers if acuity or capacity within the unit prevented timely triage and review. The NHS Tayside guidance sets out the expected maternity triage process within Ninewells Hospital. However, we observed staff were using different versions of this guidance with some staff using a hard copy of outdated guidance. During our return visit to the maternity triage department, we continued to observe variation in the approach to assessing women with staff still using different versions of the guidance. A requirement has been given to support improvement in this area.

An emergency trolley provides immediate access to critical equipment and medications during an obstetric emergency. Staff told inspectors the emergency trolley within maternity triage was in a shared location with staff describing the process to retrieve the trolley when required. However, staff also highlighted that essential medication which may be required in an obstetric emergency was not stored within the department. We were advised that this had been raised with senior managers previously, however, the issue had not yet been resolved. We raised this with senior managers to seek assurance regarding access to essential medication in an emergency situation. Senior managers advised that the medication was available, and all staff had been provided with information on how to access this. However, during our revisit staff we spoke with were unsure of both the location of the emergency medication and the process for accessing this in an obstetric emergency. Labour ward staff reported they were also unaware that emergency medication for maternity triage was being stored in the labour ward and were unable to describe the process should maternity triage need access to the medication. A requirement has been given to support improvement in this area.

The labour ward within Ninewells Hospital comprises of five birth rooms, a six-bed observational area, which includes two high dependency beds, and a bereavement

suite. On the first day of inspection the ward was experiencing high acuity and staffing pressures resulting in delay in the induction of labour process. Despite this, the ward was calm with good visibility of staff and clinical leadership.

At the time of inspection, we observed delays to the induction of labour process of up to 72 hours. Induction of labour is a practice that is undertaken to artificially induce labour; this can be in response to concerns with the mothers or unborn baby's health.

Delays to the induction of labour process are associated with increased risk of adverse maternal and perinatal outcomes. We observed these delays being escalated by senior charge midwives at the site wide safety huddle for senior management oversight. NHS Tayside have an established induction of labour safety tool in place to risk assess and escalate delays to senior hospital managers. We observed mitigations were in place to reduce risks associated with an extended delay. Mitigations included assessment of maternal and fetal wellbeing with a full antenatal assessment of women and electronic fetal monitoring (cardiotocography) for the unborn baby. NHS Tayside offer an induction of labour leaflet to inform women that delays to the procedure may occur and the process for women to follow if they have any concerns. On discussion with women, they highlighted being updated by the multidisciplinary team during delays to the induction of labour process. However, women described staff being unaware of their overall obstetric and medical history resulting in them repeating essential information to different members of the maternity team. This could cause frustration during their pregnancy journey.

The nurse call system within labour ward can play a critical safety role for the escalation of clinical concern within birthing rooms and the surrounding area. On inspection we observed that due to a battery replacement being required, part of the system alarmed continuously which impacted staff's ability to identify when the call bell was being activated from different rooms. The emergency nurse call alarm was not affected. Staff informed inspectors this has reoccurred over the past five months. However, staff were unclear of who had general oversight of the issue within the department to ensure this was escalated and resolved in a timely manner. On discussion with senior managers, it was highlighted that concerns surrounding the system had been escalated to senior managers and had been ongoing for a period of months. Due to the potential impact on the safe delivery of care, we requested the system was reviewed as a matter of urgency and senior managers responded promptly to ensure the system was fully functional. During our revisit, the call bell system was in working order.

Electronic fetal monitoring is a tool to assist assessment of fetal wellbeing. We observed that equipment required to perform cardiotocography was limited as several of the leads for the cardiotocography monitors, which allow fetal heart and uterine activity recording, were missing. This resulted in only three of five of these monitors being in full working order for five labour rooms. Staff were not aware if replacement leads had been ordered. We raised these concerns with senior managers at the time of the inspection. NHS Tayside responded promptly with evidence ensuring the

equipment was replaced and there was a sufficient number of working cardiotocography equipment available. During our revisit we observed the equipment was available with staff describing no further concerns. A requirement has been given to support improved oversight in this area.

The National Bereavement Care Pathway Scotland is a project funded and developed by Scottish Government in partnership with Sands, the stillbirth and neonatal death charity, with the aim of standardising and improving the quality of bereavement care for the families of Scotland. Further information can be found here. During our inspection we observed a dedicated bereavement room within the labour ward setting which encompassed an area to allow the full in hospital bereavement journey to be undertaken. This provided a private area to discuss options, birth and spend family time following the death of a baby. We observed opportunities for families to make memories with the option for professional photographs. Within the labour ward the role of the bereavement lead is undertaken by one of the senior charge midwives. Evidence supplied by the board highlighted bereavement training opportunities for staff at both local and national level. However, NHS Tayside could not provide information on staff bereavement training compliance rates. Staff bereavement training is a recognised standard recommended by the National Bereavement Care Pathway. A recommendation has been given to support improvement in this area.

Antenatal and postnatal care provision within Ninewells Hospital is based in one ward which consists of 42 beds and incorporates an area for transitional care. Transitional care units offer additional support to babies above normal neonatal care with the aim to prevent separation of mum and baby and unnecessary admissions to the neonatal unit. The vision for maternity services across Scotland set within The Best Start: A five-year forward plan for maternity and neonatal care in Scotland, is one in which parents and babies are offered truly family centred and compassionate care. On inspection, we observed the transitional care, located within the postnatal ward area, was closed and staff reported this was due to staffing pressures. Senior managers told us transitional care was being provided within NICU in a nursery setting at the time of the inspection.

We observed restricted visiting times within the antenatal and postnatal ward which staff advised had been in place since the pandemic. Staff told inspectors about facilities to allow women's partners or significant person to stay overnight however, this was limited and impacted by the layout of the environment and the availability of only a small number of chairs or additional beds. To support improvement in this area a recommendation has been given.

The impact of inequalities within maternity services has been highlighted through national reports such as saving mother's lives, improving care (MBBRACE 2024). All women, birthing people and their families deserve safe, kind and accessible care throughout their pregnancy journey. NHS Tayside have an addressing inequality in maternity services (AIMS) group which identify priorities for action to improve the multiprofessional care, experience and outcomes for women, birthing people and their babies. Staff we spoke with told us that if communication barriers occur for

woman and birthing people, staff are able to access both online and in person interpretation services as required. Staff reported the system worked well and included options for British Sign Language. Face to face interpretation services were available. However, staff reported variation in the access to interpretation services depending on the day and timing of the requests. They also advised that they do not routinely submit incident reports if any issues arise with interpretation or translation services. Encouraging the reporting of interpretation incidents may help NHS Tayside to understand and support any improvements in this area. A recommendation has been made to support improvement in this area.

Ethnicity data is vital information in pregnancy as it helps to identify and address inequalities in maternal and perinatal adverse outcomes. Ethnicity data reviewed through NHS Tayside's latest perinatal mortality review report demonstrated 31% of ethnicity data was not recorded for stillbirth and neonatal deaths which occurred within the board. We highlighted this information during discussions with senior managers, however they were not aware of the data highlighted within the perinatal mortality report and described this as inaccurate. This is data NHS Tayside has provided to the national perinatal mortality review and had supplied to the inspection team within evidence requested. Senior managers later provided additional information that highlighted differences from NHS Tayside's data and that within the perinatal mortality report. As senior managers did not appear to be aware of the board's own data within the perinatal mortality report this may limit the opportunity for NHS Tayside to make improvements in this area. A requirement has been given to support improvement in this area.

Communication is key in all clinical areas where there may be multiple handovers of care in short periods of time or during emergency situations as this helps to maintain situational awareness. Situation, Background, Assessment and Recommendation (SBAR) handover tools have been recognised as an effective way to optimise communication of critical information in the aim to reduce risk of adverse events and improve safety. Within Ninewells Hospital, the situation, background, assessment and recommendation tool is utilised during escalation and transition of care. However, staff described inconsistent use of the standardised tool with many handovers being verbal. Within evidence from incident reviews and clinical governance minutes provided, the need to improve communication within maternity services was highlighted as a recurring theme. Staff also described variation when documenting the handover with some staff utilising paper documentation whilst others use the function within the electronic patient record. We were provided with evidence which highlighted ongoing improvement work to established staff learning to improve communication.

Inspectors observed that there was no fire evacuation signage in place for the majority of the antenatal/postnatal ward and fire doors had loose protective door seals. Fire exit signage contributes significantly to the overall preparedness of the environment ensuring swift and safe evacuation in the event of a fire. We highlighted our findings to the senior charge midwife for the area as well as hospital managers during

inspection for immediate action. Requested evidence from NHS Tayside included the latest fire risk assessment for the ward, which demonstrated the concerns raised on inspection had previously been identified by NHS Tayside's internal fire risk assessments in September 2024. An action plan was contained within the assessment. However, some deadlines for improvement had not been met including an action to resolve the fire signage issue. Evidence of staff fire safety mandatory training was also provided by senior managers demonstrating 80% staff compliance for this training. During our return visit we observed fire signage had been addressed and was in place. A requirement has been given to support improvement in this area.

Areas of good practice

Domain 1	
1	Wards inspected were calm with good visibility of staff and clinical leadership.
2	We observed a dedicated bereavement room which encompassed an area to allow the full in hospital bereavement journey to be undertaken.

Recommendations

Domain 1	
1	NHS Tayside should ensure improvement in their assurance of staff bereavement training.
2	NHS Tayside should ensure processes are in place to support mothers and babies to have access to family centred care with extended family members actively encouraged to engage in maternal and newborn care.
3	NHS Tayside should consider ways to improve oversight and staff feedback of interpretation services, to ensure any areas for improvement can be identified and addressed.

Requirements

Domain 1	
1	NHS Tayside must ensure a system is in place to monitor women requested to attend for review following telephone triage and should inform women of the urgency and timeframe for attendance.
2	NHS Tayside must ensure signage is in place to provide clear instruction and direction to the public within the hospital environment. This includes, but is not limited to, maternity triage.
3	NHS Tayside must ensure effective oversight of guidance and process within maternity triage to support safe delivery of care.
4	NHS Tayside must ensure medication required for emergency treatment is accessible to staff with effective oversight and assurance of staff knowledge of process.

5	NHS Tayside must ensure effective oversight to ensure essential patient equipment is in working order and ready for use. This includes, but is not limited to, fetal monitoring equipment.
6	NHS Tayside must ensure improvement in governance and oversight of ethnicity completeness data for all women and birthing people booking for perinatal care.
7	NHS Tayside must ensure all fire exit signage is present and maintained to ensure safe fire evacuation and actions and improvements identified within fire safety risk assessments are addressed.

Domain 2 – Leadership and culture

Quality indicator 2.1 – Shared values

We observed good teamwork, including extended members of the multidisciplinary team such as obstetricians, midwives and the health care support team. However, we received varied feedback from clinical staff regarding support from senior managers, with some staff describing a disconnect between ward staff and senior managers.

We were able to attend the multidisciplinary team morning huddle within labour ward, where the obstetric, midwifery and anaesthetic team were represented. This was a comprehensive overview of women within maternity services led by the consultant team with good discussion evident. The huddle allowed for full unit acuity discussion promoting oversight and situational awareness.

We were able to observe how maternity services fed into the wider hospital safety huddle. The hospital safety huddles were held throughout the day and were attended by members of the multidisciplinary team including nursing, midwifery, allied health professionals, hospital discharge team and facilities colleagues. The wider hospital safety huddle supports site wide situational awareness, including patient flow, patient safety concerns, review of staffing and identifying wards or areas at risk due to reduced staffing levels. We observed evidence of maternity services staffing, acuity, capacity and safety concerns being raised. We observed open and supportive conversations, with delays to the induction of labour process highlighted during the huddle.

During the onsite inspection we had the opportunity to discuss the adverse events process with senior managers who described the governance in the management of adverse events and reviews, with reviews occurring weekly. They described participation in the board wide standardisation of recognition, escalation and commissioning of significant adverse events review. The national perinatal mortality review tool is a national tool designed to standardise review and learning following the death of a baby. NHS Tayside utilise the tool for review of all stillbirths and neonatal deaths and evidence requested demonstrated learning summaries are utilised to share

learning from reviews with staff. The quality lead midwife described involvement with families in the significant adverse events review process, with the perinatal mortality review family leaflet detailing how families can be involved as part of the review undertaken.

During inspection staff described an improvement in feeling supported following adverse events with peer support available and the engagement of the wellbeing service if required. Staff reported timely feedback from submission of incident reports following an adverse event. Within evidence provided by NHS Tayside we observed an incident trigger list. This aims to encourage submission of an incident form following an adverse event to ensure a review and learning is undertaken. Staff described the use of hot and cold debriefs which aim to identify immediate patient safety risks and provide peer support to staff.

We requested details of any reported patient safety incidents that had occurred over the three months prior to our inspection. Thematic review of incident reports submitted identified a theme of babies born with low umbilical cord gas pH and unplanned admission to the neonatal unit for care. Low umbilical cord blood pH at birth is associated with adverse neonatal outcomes such as brain damage and neonatal death. NHS Tayside provided evidence of their clinical governance oversight group which highlights cardiotocography interpretation, escalation and communication of clinical concern as recurring themes following review. NHS Tayside appear to have systems and processes in place to ensure learning from adverse events, including sharing learning reviews with staff and weekly multidisciplinary cardiotocography training. However, in evidence provided we observed instances where staff training to support learning from adverse events was, at times, cancelled due to staffing issues and faculty availability. This is described later in the report within domain 4.3.

A positive working culture is essential to the safe delivery of care. This has been evidenced through national reports into reviews of maternity care such as Kirkup (2015) and Ockenden (2022). During inspection we observed a positive working relationship within the clinical team. However, staff described disconnect with senior managers in relation to responding to mitigations when escalation of staffing and patient safety concerns occurred. On discussion with staff and senior managers we were told culture within the service is an area for improvement. Staff described culture impacting on staff morale and resulting in stressful working conditions. Staff described a lack of visible senior leadership resulting in some staff finding it difficult to ask for support at times of high acuity. We raised concerns regarding culture with NHS Tayside within our letter to the executive team. We were provided within evidence information regarding work which was being undertaken around culture within the maternity services. The initial aim of this piece of work was to explore culture and civility within the unit to highlight areas to focus improvement work. We observed feedback sessions for staff had been arranged. However, these had been poorly attended. On discussion with both staff and senior managers they were open and

transparent regarding the current culture within the unit reporting a noticed improvement in recent months.

Areas of good practice

Domain 2	
3	We observed clinical leaders within maternity services being approachable and engaging with all team members.
4	New members of the multidisciplinary team reported feeling able to discuss concerns and escalate any issues.
5	An incident trigger list which aims to encourage submission of incident report forms following an adverse event was in place to support review and learning.

Domain 4.1 – Pathways, procedures and policies

Quality 4.1 – Pathways, procedures and policies

Despite the pressures on maternity services during the time of inspection, women and their babies appeared well cared for with families speaking highly of care received. We observed areas for improvement in the escalation of care, with some improvement work underway. We also raised concerns with NHS Tayside regarding the environment within maternity wards.

Quality improvement aims to make a difference to women and birthing people by improving safety, effectiveness, and experience of care. We asked for evidence of data oversight and quality improvement initiatives to improve patient safety and experiences within the maternity services. The Scottish maternity early warning score (MEWS) is a bedside screening tool which supports observation of physiological parameters such as blood pressure and heart rate in an aim to improve the recognition of pregnant and postnatal women at risk of clinical deterioration. This facilitates early intervention to improve outcomes. We were provided with evidence which included findings from MEWS audits undertaken by NHS Tayside. These highlighted delays in escalation to the senior maternity team for review when women demonstrated signs of deterioration in their clinical condition as a recognised area for improvement within maternity services. We discussed this with senior managers who told us of a current improvement project in the form of an online learning module to support staff education, improve completion of MEWS charts and improve escalation to senior maternity staff when deterioration of women is presenting. We were provided with evidence demonstrating improving compliance with MEWS completion within maternity services. Senior managers also informed us of improvement work within the wider hospital setting to alert staff members of a pregnant or recently postnatal woman who may present out with maternity services to ensure they are monitored using a maternity early warning chart.

Mother and babies: reducing risk through audits and confidential enquiries across the UK (MBBRACE-UK) aim to improve outcomes for women and babies through learning from national audit. The 2024 report demonstrated the leading cause for maternal death in the UK being attributed to venous thromboembolism. Learning from the report highlighted a need for continuous evidence-based risk assessment throughout pregnancy and following birth. Within incident reports provided by NHS Tayside we observed that errors regarding venous thromboembolism risk assessments and medication were in the top five most reported patient safety incidents reported by staff in the three months prior to our inspection. NHS Tayside provided us with their 'Prophylaxis of Venous Thromboembolism' guideline, which was due for review in February 2025 however, some of the national guidance contained within this document was out of date. We highlighted this to senior managers who advised us that as well as the guideline in place, the electronic patient record provided staff with guidance when completing venous thromboembolism risk assessments. Senior managers advised us this would provide the most up to date national guidance to support staff at the time of the risk assessment. On discussion, senior managers acknowledged this may present conflicting advice to staff during the assessment of women's risk and need for prophylactic treatment of venous thromboembolism. Senior managers informed us of their plan to review and align all guidance for venous thromboembolism within NHS Tayside. During the inspection we asked staff about the application of the guidance within clinical areas and about any quality assurance audits carried out to assure compliance with the risk assessments. However, staff explained care assurance audits undertaken to support compliance with risk assessment and guidance were not regularly carried out and this was due to staffing pressures and acuity within the unit. We discussed this with senior managers to ask about any other assurance work being carried out to support compliance however no further assurance could be provided. A requirement has been given to support improvement in this area.

NHS Tayside utilise electronic patient records for documentation of all care episodes through the maternity care journey. At the time of inspection documentation within the electronic patient record was not reviewed due to limited access being available. We asked NHS Tayside to provide evidence of processes in place to audit documentation and discussed with senior managers current oversight for improvement. Senior managers described a current improvement focus to streamline all documentation audits currently undertaken within the service to ensure all learning identified through audit is applied to practice. Within evidence reviewed clinical governance papers highlighted documentation as an area for improvement. A requirement has been given to support improvement in this area.

Inspectors observed evidence of wear and tear throughout the hospital environment. The original Ninewells Hospital is now approximately 50 years old. Inspectors observed shower areas with cracked and bubbling paint and flooring lifting at the seams which presented a potential trip hazard. As mentioned at the beginning of the report, maternity services was inspected in conjunction with the general hospital. Whilst areas

for improvement regarding the environment had been identified in the acute hospital inspection, we observed that the environment within maternity services did not seem to be maintained to the same standard as the rest of the hospital. We spoke with senior managers who told us of the challenges in maintaining the environment due to the age of the building. However, senior managers described an ongoing rolling programme of refurbishment within clinical areas. Maintenance of the hospital is undertaken as a whole, with the maintenance team describing a well embedded system of notification, follow up and escalation of the environment. Staff described their working environment having a negative effect on staff wellbeing and care provision. Poor maintenance of the environment can also impede effective cleaning.

Care assurance audits are undertaken to assure care provided is in line with current guidance and standards. During inspection we discussed care assurance audits undertaken within the antenatal and postnatal ward and any quality improvement projects currently in progress. Staff reported challenges undertaking audits due to staffing pressures and described limited action taken when completed audits demonstrated areas for improvement. Within evidence provided we observed some of the areas for improvement identified by inspectors, for example relating to the poor condition of the environment in some ward areas, had been highlighted previously as areas requiring improvement through NHS Tayside's audits system. However, despite having action plans in place, improvements had not been actioned, resulting in some of the same areas for improvement being identified by inspectors. To support improvement in this area a requirement has been given.

During inspection we observed breastfeeding equipment being cleaned in a sink in the kitchen area within the antenatal and postnatal ward. This was beside the cleaning area for other eating and drinking utensils with the opportunity of cross contamination. A ceiling tile directly above the sink area was also missing with staff describing escalation of this to appropriate teams for repair. We raised the condition of the environment with senior managers during our initial inspection, and on our return visit some of the outstanding work was completed. However, the missing ceiling tile directly above the sink area had not been replaced and the cleaning of breastfeeding equipment had not been separated from the general washing up area. Following the return visit, we were provided with evidence of this work now being complete. A requirement has been given to support improvement in this area.

During inspection we observed mealtimes which were well organised. We observed that staff were aware of women's dietary requirements. We observed food and fluid being available to women within all areas of maternity services. We observed areas of good practice, with families being supported by the infant feeding team and wider staff groups to build confidence in their chosen feeding method of their baby.

Hand hygiene is an important part of standard infection control precautions to minimise the risk of infection. Other standard infection control precautions include patient placement, the use of personal protective equipment (such as gloves and aprons), management of the care environment, safe management of blood and fluid

spillages, linen and waste management and prevention and exposure management (such as sharps injuries). On inspection we observed that there were occasions where staff missed opportunities to clean their hands including before and after contact with patients. This was also highlighted as an area for improvement within the wider acute hospital inspection. A requirement has been given to support improvement in this area.

Personal protective equipment such as gloves and aprons were readily available at the point of care. Inspectors observed appropriate use of personal protective equipment.

Clean linen should be stored in a linen cupboard with the door closed or an appropriate identified covered trolley to minimise the risk of contamination. Inspectors observed that in some areas the covers on clean linen storage trollies were not always in place. This is not in line with the national infection and control manual. Used linen that is contaminated with blood and/or other body fluids should be placed into a water-soluble alginate bag then placed into a clear bag to prevent the risk of contamination. However, inspectors observed that in some ward areas staff were not placing the alginate bags into a clear outer bag and contaminated linen was incorrectly disposed of. A requirement has been given to support improvement in this area.

Inspectors observed that in most areas chlorine-based cleaning products were not stored securely, resulting in a risk that it may be accessed by women, children and members of the public. We observed chlorine-based cleaning products stored in domestic storerooms which were situated in main corridors of the hospital as well as reconstituted cleaning solution stored in unlocked dirty utility areas and laundry baskets. Inspectors also observed in one clinical area that reconstituted cleaning products were stored in bottles with inappropriate lids. This is not in line with The Control of Substances Hazardous to Health (COSHH) Regulations 2002 which stipulate that these products must be kept in a secure area such as a locked cupboard.

The national infection prevention and control manual recommends cleaning products should be freshly made and discarded after 24 hours. However, inspectors observed that bottles were not marked with the date and time of when chlorine-based cleaning products were reconstituted. This would make it difficult for staff to know when the cleaning solution should be discarded.

We raised this with senior managers at the time of inspection and we observed staff being informed of this during hospital safety huddles. Senior managers distributed posters to staff containing information on the safe use and storage of chlorine-based cleaning products. However, we continued to observe poor compliance with the secure storage of chlorine-based cleaning products throughout the remainder of the onsite inspection and during our revisit in February. A requirement has been given in both the hospital and maternity inspection reports to support improvement in this area.

We observed poor compliance with sharps management in all areas such as sharps containers not having temporary closures in place. The use of the temporary closure

prevents needles or other sharp objects protruding from the boxes or falling out of the container if it is dropped. Inspectors observed that in many of the clinical areas there was a build-up of clinical waste bags awaiting collection as there was insufficient storage for large clinical waste bins. Senior managers explained that the portering service attend clinical areas on a regular basis to uplift clinical waste. We were also told that waste was kept in controlled access rooms such as the dirty utility areas and that all waste is closed and tagged as per current guidance in the National Infection Prevention and Control Manual. Senior managers explained that staff in clinical areas should escalate to the facilities team if additional waste collections were required. NHS Tayside did provide evidence of the scheduled collection times that portering staff attend clinical areas between the hours of 06:00 and 22:00, however this did not appear to be sufficient to manage the build-up of waste observed during the inspection. During our corresponding hospital inspection, we also observed a build-up of clinical waste bags awaiting collection. A requirement has been given to support improvement in this area.

Transmission based precautions are additional infection control precautions that should be utilised by staff when caring for a patient with a known or suspected infection. On observation we noted areas where these precautions were in use with clear signage in place and staff were observed correctly using personal protective equipment within the area. However, staff explained that when precautions are no longer required, this is not effectively communicated to them. We raised this at the time of inspection with the senior charge midwife for the area.

Care equipment can be easily contaminated and a source of transferring infection if equipment has not been effectively cleaned. During inspection the majority of patient care equipment was clean and ready for use. Storage issues within clinical areas resulted in equipment being stored in corridors within wards, however this did not appear to cause any obstruction or impact on the safe delivery of care.

During inspection we spoke with staff regarding water flushing regimes within maternity services. Water flushing regimes support the prevention of the build-up of bacteria within the water system. On discussion staff could not describe water flushing regimes undertaken within their area or provide quality assurance audits regarding water flushing. Evidence provided demonstrated limited assurance that water flushing was being carried out in line with guidance. This was also identified as an area for improvement within the acute hospital inspection. A requirement has been given to support improvement in this area.

During inspection medication trollies were locked and adequately secured. However, medication cupboards were unlocked and could have been accessed by women or members of the public. This is not in line with the professional guidance and administration of medicines in healthcare settings Royal Pharmaceutical Society and the code by the Nursing and Midwifery Council. Within clinical areas fridges allocated for medication were noted to be unlocked and have two temperature gauges, one outside and one inside the fridge from which clinical assurance audits were

undertaken. Inspectors raised this with the senior charge midwife for the area to ensure correct storage of medication was being complied with. A requirement has been given to support improvement in this area.

Areas of good practice

Domain 4.1	
6	We observed families being supported by the infant feeding team and wider staff groups to build confidence in their chosen feeding method of their baby.

Requirements

Domain 4.1	
8	NHS Tayside must ensure venous thromboembolism guidance and risk assessments in place are aligned to support staff during the risk assessment of venous thromboembolism.
9	NHS Tayside must ensure robust processes are in place to support quality assurance processes within maternity services.
10	NHS Tayside must ensure effective systems and process are in place to support assurance of a safe healthcare environment and that all essential maintenance works are completed.
11	NHS Tayside must ensure compliance with SICPS this includes but is not limited to: a. hand hygiene b. linen management c. sharps management
12	NHS Tayside must ensure all hazardous cleaning products are securely stored and labelled appropriately, as per manufacturers' guidelines.
13	NHS Tayside must ensure that clinical waste is stored in a designated safe, lockable area whilst awaiting uplift and staff are aware of how to escalate if there is a buildup of clinical waste awaiting uplift.
14	NHS Tayside must ensure infrequently used water outlets are flushed in line with current national guidance.
15	NHS Tayside must ensure the appropriate management and monitoring is in place to ensure the safe storage of medicines.

Domain 4.3 – Workforce planning

Quality 4.3 – Workforce planning

We observed some areas of good leadership with senior charge midwives visible in all wards. Staff described feeling supported to escalate staffing issues. However, staff spoke of challenges providing different aspects of maternity care and found it challenging to always maintain patient safety when skill mix within the team was not optimal. NHS Tayside were unable to provide assurance regarding staff appraisals within the midwifery team.

NHS Tayside use an electronic staffing system which monitors real time staffing levels in relation to patient care needs. This provides a traffic light system with red areas having the highest shortfall of staff available to meet women's needs. This enables informed decisions to be made when deploying staff to help mitigate risk and considers the acuity of the women and babies versus available staffing numbers allowing for professional judgement to be made in terms of required staffing. This system has been well established within the acute nursing team in NHS Tayside, however, is relatively new to maternity services with senior managers informing us implementation began towards the end of 2024. During on-site inspection, it was observed that while there was input from maternity services into the site huddles, the process for real time staffing risk assessment and management within maternity was not clear. A requirement has been given to support improvement in this area.

We observed senior clinical leaders within maternity services were approachable and engaging with all team members. New members of the multidisciplinary team reported feeling able to discuss concerns and escalate any issues. We observed supportive interactions between the team around care provision with prompt escalation observed to activate the multidisciplinary team when clinical need arose. Ward areas remained calm, and staff were organised during rapidly changing levels of acuity and activity. However, some clinical staff described disconnect with senior managers in relation to different aspects of safe delivery of care regarding safe staffing, action and support when clinical concern arose. Staff described this as impacting on psychological safety, low morale and stressful working conditions. Within evidence provided NHS Tayside detailed escalation policies in relation to staffing issues and escalation in time of high acuity impacting safe delivery of care. However, during inspection staff told inspectors they sometimes felt that concerns escalated to senior managers due to increased acuity were not always responded to or variation in response was given. A requirement has been given to support improvement in this area.

During inspection we attended maternity services staffing huddles led by senior charge midwives. The huddle included midwifery workforce planning for both onsite and offsite maternity services within NHS Tayside. We observed open and transparent discussions regarding potential staffing issues. In evidence provided, we observed that maternity services have adapted the Operational Pressures Escalation Levels (OPEL)

Framework. The aim of OPEL is to ensure patient and staff safety and outlines the leadership and actions required during times of extremis in the maternity system. However, during the staffing huddle attended we did not observe the OPEL tool utilised to signify the extent of risk within the current system or to apply mitigations when staffing was not optimal. We raised this with senior managers during the onsite inspection. A requirement has been given to support improvement in this area.

Workforce data reviewed for NHS Tayside demonstrates a significant (33%) shortfall in the band 6 midwifery staffing establishment. We consider a rate of over 10% high. Within evidence reviewed the band 6 shortfall has been filled by band 5 newly qualified midwives. During inspection, band 5 midwives reported feeling well supported within the clinical area and through the preceptorship programme currently in place within NHS Tayside. However, band 6 and band 7 midwives described the shortfall impacting on staff development as they were unable to provide quality professional support in times of high acuity impacting on job satisfaction. We were informed of escalation processes that are in place in relation to staffing risk, and how staffing risks are routinely reviewed within and across the hospital. However, concerns remain that although there are processes in place, there is a lack of assurance as to if and how these processes are used and understood within maternity services. On discussion with senior managers no further assurance could be demonstrated.

The Health and Care (Staffing) (Scotland) Act 2019 commenced on 1 April 2024. It stipulates that NHS boards have a duty to apply the Common Staffing Method (CSM), which includes a staffing level tool run and requires this to be applied rigorously and consistently. The application of the common staffing method and staffing level tools supports NHS boards to ensure appropriate staffing, the health, wellbeing and safety of patients and the provision of safe and high-quality care.

In the review of evidence staffing level tool runs were incomplete due to missing data regarding professional judgement. Following discussion with senior managers there remains a lack of assurance as to how senior managers are mitigating the gap in skill mix, experience and leadership and how these impact upon quality, safety and staff wellbeing. Application of the Common Staffing Method would support senior managers to better understand this to inform appropriate staffing requirements at all agenda for change bands within the midwifery team.

Through evidence received, we observed high levels of absence within Maternity Services of over 30%. The national target for predicted absence within nursing and midwifery services is 22.5%. This is built into staffing establishments to ensure consistent cover. NHS Tayside use supplementary staffing for example bank, agency or overtime to help cover staffing shortfalls left by absence, vacancy and increased service demand. Within the evidence submitted we observed that there was still a significant variance of 9.3% between the planned staffing (funded establishment) and actual staffing once vacancy, absence and supplementary staffing use has been considered. Through evidence received and in discussion with senior managers it

remains unclear how this gap was or continues to be mitigated. A requirement has been given to support improvement in this area.

There is currently no real time staffing tool for professional groups such as obstetricians and anaesthetists. We asked senior managers how they monitored safe staffing for these professional groups and how risks within these groups were captured, escalated and mitigated. On discussion with senior managers, it remains unclear as to how professional groups other than midwives associated with maternity services are assessing and managing real time staffing risk.

During inspection we were informed of different staff wellbeing initiatives within maternity services. These included recent improvement work by the obstetric team to ensure foundation year doctors receive protected mealtimes. We observed the wellbeing room within labour ward, a dedicated area for staff to relax on break times. Senior managers also provided evidence of staff development opportunities from the preceptorship programme which spans the first year of the newly qualified midwifery role, to leadership opportunities within senior managers. We observed evidence that senior managers also intend to host what matters to you events throughout 2025.

To support safe delivery of care within maternity service during staff shortfalls, staff described frequently being moved to different wards to work part of or all of their shift. Staff having the right skills and knowledge within their area of practice is essential in the safe delivery of care. On inspection and discussion with senior managers, we asked how staff are supported to maintain skills and knowledge to enable transition safely between areas of maternity services. Staff appraisals are essential to assessing and supporting staff performance resulting in a positive work culture. In evidence received we observed obstetric staff could demonstrate 100% compliance rate with appraisals. NHS Tayside were unable to provide assurance of appraisals being carried out for midwifery staff. We asked for evidence of appraisals carried out in the last 12 months within the antenatal/postnatal ward. Senior managers were unable to provide evidence of assurance that these had been carried out. During discussions senior managers told us appraisals for midwifery staff within Ninewells Hospital is an area for improvement and is part of an improvement plan to support appraisals throughout 2025. A requirement has been given to support improvement in this area.

In response to Healthcare Improvement Scotland review of maternity services within NHS Ayrshire and Arran, core mandatory training requirements for Midwives and Obstetricians in Scotland was published by Scottish government in 2018. This required each NHS board to establish training around fetal (unborn baby) heart monitoring, obstetric emergencies and neonatal resuscitation. Wider national reports on the provision of safe maternity care over the last decade such as Ockenden (2022), Each baby counts (RCOG 2019) and Kirkup (2015) have highlighted the essential safety feature of teams working and training together to improve outcomes for families. During inspection, staff told us about mandatory training being cancelled due to staffing levels and acuity within the service. Evidence received demonstrated that over

the last year 67% of the multidisciplinary team had undertaken practical obstetric multiprofessional training (PROMPT) and 70% of staff had undertaken cardiotocography training. However, this was not broken down to represent specific staff group compliance. On discussion with senior managers, they were not able to provide further overall assurance on different staff group compliance rates. Within evidence reviewed neonatal resuscitation compliance rates for midwives were 44% within the yearly requirement and 76% within the four yearly requirements. Staff also informed inspectors they did not have protected work time to complete online education resulting in this being carried out mostly in their own time. A requirement has been given to support improvement in this area.

Time to lead is a legislative requirement under the Health Care Staffing (Scotland) Act (2019). This is to enable clinical leaders to provide and oversee the delivery of safe, high quality and person-centred healthcare.

Senior midwifery and senior obstetric leadership are fundamental to the delivery of safe care. During the onsite inspection senior managers informed us of current changes to, and vacancies within, the senior midwifery team. This can impact on effective leadership and oversight of service delivery and support for staff. Following the inspection, NHS Tayside advised us of their commitment to a strong professional leadership and have subsequently reappointed to vacancies which were advertised for recruitment during our inspection. The obstetric team advised us there was no current vacancies at the time of inspection.

Each senior charge midwife is responsible for a midwifery team. This includes quality and performance management, HR requirements, ensuring training is up to date and wellbeing support for their team. We were told that senior charge midwives have one management day allocated per week however, that they are often required to take a clinical caseload as mitigation for staffing shortfalls. This impacts on their capacity to complete their leadership and management responsibilities. Evidence submitted demonstrates that senior charge midwives' leadership time was impacted during 45% of shifts which would impact on the senior charge midwives protected time to lead. A requirement has been given to support improvement in this area.

Areas of good practice

Domain 4.3	
7	NHS Tayside utilise a variety of initiatives to support staff health and wellbeing.

Requirements

Domain 4.3	
16	NHS Tayside must ensure that clear and robust systems and processes are in place to allow consistent assessment and capture of real time staffing risk across all clinical professional groups within maternity services to support consistent management of any identified staffing risks. This must include feedback to staff regarding decisions undertaken.
17	NHS Tayside must ensure there are clear systems and processes in place for the monitoring and mitigation of any severe and/or recurring staffing risk within maternity services to support longer term workforce planning and service improvement.
18	NHS Tayside must ensure that there are clearly defined systems and processes in place within maternity services to support effective leadership and oversight relating to appropriate staffing requirements as defined within the Health and Care (Staffing) (Scotland) Act 2019. This includes, but is not limited to, the monitoring and mitigation of the impact of staffing challenges, including reduced skill mix.
19	NHS Tayside must ensure they are complying with the duty imposed by section 12II, ensuring that its employees receive time and resources to undertake such training essential to their role.
20	NHS Tayside must ensure that there are systems and processes in place to support clinical leaders within maternity services being able to access appropriate protected leadership time to fulfil their leadership and management responsibilities. This will include consistent monitoring and recording of when and why this is sacrificed as part mitigation for staffing shortfalls.

Domain 6 – Dignity and respect

Quality 6.1 – Dignity and respect

Women we spoke with said they felt listened to and supported in their care decisions and the majority of women we spoke with, described positive communication and compassionate care. Women and their families advised they would be happy to recommend NHS Tayside maternity services to family and friends.

All interactions we observed between women, babies and families were positive and respectful. Women we spoke with described staff as being responsive to their needs and spoke highly of the staff and the care provided. Women described receiving good communication from the multidisciplinary team. Women described receiving assistance when required and access to analgesia when needed.

We observed staff working hard to provide compassionate, responsive and respectful care. Women, families and visitors that we spoke with were complimentary about staff

and the care provided. Inspectors observed staff taking time to answer any questions and allowing the women and families time to ask further questions. During observation within maternity triage, we observed toilet facilities which could limit a right to privacy. A hatch used to supply a urine sample offered two points of access, one within the toilet and one within the sluice area with no lock available to secure privacy. No signage was in use to identify when the toilet was occupied. Due to the potential impact to privacy when utilising the toilet, we raised this with senior managers, who advised they would review the facilities and ensure a process to maintain dignity.

We observed staff working to maintain privacy and dignity, utilising a dedicated side room to ensure privacy was maintained during induction of labour procedures. However, during observation within the labour suite, we were informed women have no access to toilet or washing facilities within the birthing rooms. Women are required to utilise one of the three bathrooms available within the labour ward including advanced stages of labour and in the immediate postpartum period. Inspectors raised with senior managers the possible lack of dignity for women especially through the labour process. Senior managers recognised the lack of toilet facilities however, explained the space available within the environment prevented toilets being added to this area and described staff's commitment to supporting dignity at vulnerable times. Staff were observed supporting women with personal care when required and no women we spoke with raised this as an area of concern.

We observed evidence of family-centred care in labour ward, and it was evident that staff were aware of how positively this impacts the family's experience.

Areas of good practice

Domain 6	
8	All observed interactions between women, staff and visitors were positive and respectful.
9	We observed staff working hard to provide compassionate, responsive and respectful care.

Appendix 1 - List of national guidance

The following national standards, guidance and best practice were current at the time of publication. This list is not exhaustive.

- Allied Health Professions (AHP) Standards (Health and Care Professionals Council, September 2024)
- Antenatal care guideline (National Institute for Health and Care Excellence, August 2021)
- CMO (2018) 18 Core mandatory update training for midwives and obstetricians (Scottish Government, December 2018)
- Fire Scotland Act (Acts of the Scottish Parliament, 2005)
- Food, Fluid and Nutritional Care Standards (Healthcare Improvement Scotland, November 2014)
- Generic Medical Record Keeping Standards (Royal College of Physicians, November 2009)
- Maternity Triage Good Practice Paper No. 17 (Royal College of Obstetricians & Gynaecologists, December 2023)
- Health and Care (Staffing) (Scotland) Act (Acts of the Scottish Parliament, 2019)
- Health and Social Care Standards (Scottish Government, June 2017)
- Infection Prevention and Control Standards (Healthcare Improvement Scotland, 2022)
- National Infection Prevention and Control Manual (NHS National Services Scotland, June 2023)
- Record keeping: Guidance for nurses and midwives (Nursing & Midwifery Council, August 2012)
- Operating Framework: Healthcare Improvement Scotland and Scottish Government (Healthcare Improvement Scotland, November 2022)
- Intrapartum Care Guidance (National Institute for Health and Care Excellence, September 2023)
- Person-centred care (Nursing & Midwifery Council, December 2020)
- Professional Guidance on the Administration of Medicines in Healthcare Settings (Royal Pharmaceutical Society and Royal College of Nursing, January 2019)
- Postnatal Care Guidance (National Institute for Health and Care Excellence, April 2021)
- The best start: five-year plan for maternity and neonatal care (Scottish Government, January 2017)
- The Quality Assurance System and Framework (Healthcare Improvement Scotland, September 2022)

- Scottish Patient Safety Programme: Perinatal and Paediatric (Healthcare Improvement Scotland)
- Staff governance COVID-19 guidance for staff and managers (NHS Scotland, January 2022)
- The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives (Nursing & Midwifery Council, October 2018).

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